MONTHLY GRANT FUNDING (MGF) PAYMENT INQUIRY FORM

This form is intended to be used in those instances when a Community Partner clinic believes they should have received MGF for a MHLA enrolled participant but did not. Please complete this form in its entirety for each patient the agency is inquiring as to lack of MGF payment. Submit this form within thirty (30) days following the receipt of the prior month's payment. All fields must be filled out completely prior to submission or will be returned to the clinic. DHS-Finance will respond to this inquiry within thirty (30) days. Please attach to this document a screen shot that shows the coverage period(s) for all Participant(s) on this form. Please send this form to: MHLAMGF@dhs.lacounty.gov

Today's Date: _____
Inquiry On Behalf Of Which Payment Month: _____
Agency: _____ **Clinic Site Name**: _____

Participant Last Name	Participant First Name	Participant ID#	Date of Birth	Was this Participant enrolled in OEA for the month of inquiry ? (Y/N) Please attach a screen shot showing the enrollment dates for this Participant.	Was this Participant enrolled at your Medical Home during the month of inquiry? (Y/N)	What was the Participant's Enrollment Status during the month of inquiry? (i.e., Disenrolled, Enrolled, Denied)	If the Participant was Disenrolled or Denied, why were they Disenrolled or Denied? (i.e., Incomplete Application, Other Public Coverage/Medi-Cal, Over 138% FPL). Please review all case comments for this Participant in OEA.	If you believe this Participant was disenrolled or denied in error, please explain why.

Submitted by:_____ **Contact Number:**_____
Clinic Billing Manager, COO or CFO Signature: _____ **Please Print Manager's Name:** _____

Please submit this form no later than thirty (30) days after the receipt of the prior month's MGF payment to: MHLAMGF@dhs.lacounty.gov